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ABSTRACT

Numerous advocacy groups concerned with "death with dignity" have formed in response to medical advances which extend the process of dying. Natural death legislation and the Living Will are but two examples of suicide advocacy for the terminally ill. These groups are emerging world-wide and range from conservative insistence on passive refusal of treatment to radical suicide advocacy and the establishment of new voluntary euthanasia societies in several countries. Suicidologists and suicide-prevention workers need not regard these groups as inimical to suicide prevention: the two kinds of groups can make important contributions to each other's work. Data gathered by suicidologists and those with clinical experience in suicide prevention may be able to determine the point at which, in the normal stages of dying, the terminally ill person may be most likely to attempt or commit suicide. However, suicide advocacy suggests that sometimes such attempts should not be interfered with, since effective suicide prevention in these cases may mean forcing an individual to stay alive in intolerable circumstances. Both suicide prevention and suicide advocacy are basically humanitarian-oriented: this commitment to the interests of individual human beings provides the basis for accommodation between the two. (Author/NRB)

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ON THE RELATIONSHIP BETWEEN SUICIDE-PREVENTION AND SUICIDE-ADVOCACY GROUPS

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ON THE RELATIONSHIP BETWEEN SUICIDE-PREVENTION AND SUICIDE-ADVOCACY GROUPS

Largely in response to contemporary medicine's advancing technological capacities to extend the process of dying to extraordinary lengths, recent years have seen the emergence of numerous advocacy groups concerned with what is often called "death with dignity." The New York-based group Concern for Dying, for instance, distributes the Living Will as a means for individuals to secure their right to refuse unwanted, life-prolonging medical treatment. Another New York group, the Society for the Right to Die, lobbies for passage of "natural death" legislation, and has seen passage of Natural Death Acts in California and nine other U.S. states, and legislative consideration of similar bills in another twenty-seven. The Los Angeles-area group Hemlock, led by a British writer who helped his cancer-stricken wife drink a lethal potion, argues for societal recognition of assisted suicide as an option in terminal illness. Still more extreme, Britain's Voluntary Euthanasia Society, now renamed EXIT: The Society for the Right to Die with Dignity, has planned to publish and distribute to its members a booklet of suicide methods for use by terminally ill persons; and although the British group was forced for legal reasons to withdraw its plans, the booklet has actually been published by the Scottish EXIT. Nor are such groups a local phenomenon, but are emerging world-wide: although their views range from quite conservative insistence on passive refusal of treatment to radical

suicide-advocacy, there are new voluntary euthanasia societies in Australia, Norway, Sweden, Japan, Denmark, New Zealand, South Africa, Holland, Germany, France, Colombia, Zimbabwe, and Canada.

But the emergence of these groups may seem to pose an uncomfortable issue for both professionals and layworkers in suicidology and suicide prevention. Although their views are far from uniform, all of these groups counsel a more active role in one's own death. Some view suicide with tolerance. Some advocate suicide in certain kinds of circumstance. And some stress the importance of legalizing suicide assistance from physicians, family members, and other persons. Thus, it is very tempting to view these groups as inimical to the cause of suicide prevention, and to assume that they will seriously undermine the efforts of suicidologists and suicide-prevention workers in understanding and preventing self-destruction. But I think that this is a mistake -- a serious mistake -- and that the relationship between what we shall loosely call suicide-prevention and suicide-advocacy groups is appropriately seen in another, very different way.

First, I think it is a mistake to view the aims of these two groups as conflicting, since in fact their aims are focussed on two very different kinds of cases. It is easy to assume that the one group aims to prevent suicide, the other to promote it; but this assumption is, I think, misguided. Of course it is true that some suicide-prevention professionals have seen their mission as the prevention of suicide in any circumstances at all; and it is also true that suicide-prevention professionals often speak as if their objectives were simply to lower the rates of suicide in general, without reference to the particular facts of individual suicide cases. But

these postures are, I think, comparatively rigid, and I think it is mistaken to assume that suicide-prevention groups have sought to root out all suicide. In particular, they give remarkably little attention to preventing suicide in terminal illness. But the fact that suicide-prevention groups are rather less zealous in working to reduce the incidence of suicide in terminal illness cases is not, I think, to be attributed to any special charity or approval of such acts, but is, rather, a function of a particular statistical fact: such cases are typically not reported as suicide, either by the physician or by the coroner, and so do not appear in the suicide statistics at all. Suicide-prevention workers have concentrated considerable energy on understanding and reducing suicide among, say, adolescents or blacks or Indians, but not among the terminally ill; this is not from any greater sympathy for the terminally ill than for adolescents, Indians, or blacks, but largely because the facts of suicide among the terminally ill are rarely brought to our attention at all.

But of course, it is precisely these cases to which the suicide-advocacy groups direct their view. Most repudiate suicide for (in the words of the Hemlock manifesto) "any primary emotional, traumatic, or financial reasons in the absence of terminal illness," and all insist that they do not wish to encourage suicide among young and healthy individuals. Rather, their focus is on suicide, rationally chosen, as a means of avoiding intractable pain in terminal illness; generally speaking, that is the only situation in which they would find suicide an act to be approved. Of course, they readily admit that the distinction between "rational" suicide and other cases is not always sharp. By and large, however, they have been less

concerned with the difficulties which arise when one tries to draw this distinction in actual cases, where depression, anger, or frank psychopathology may compound terminal illness, and more concerned to arouse our sentiments by pointing to cases of ideally rational suicide as a means of "self-deliverance" from the cruelties of death.

Thus, suicide-prevention and suicide-advocacy groups have quite different cases in mind. Suicide-prevention workers typically do not notice the existence of suicide cases of the sort which suicide-advocacy groups support; and suicide-advocacy groups regard the kinds of cases suicide-prevention workers strive hardest to prevent as simply not relevant to their concerns. But to point out that these groups have different cases in mind, while it is perhaps to show that they need not be enemies, is not yet to convince us that they must work together. It is this that it is most important to do.

For consider what suicidologists and suicide-prevention workers might contribute to suicide-advocacy's concerns, and the ways in which those contributions might allay fears about irresponsibility among suicide-advocacy groups. It is true that most clinical and scientific work in the theory and occurrence of suicide has been done by research suicidologists and clinicians associated with the suicide-prevention movement; in contrast, suicide-advocacy groups, though with some exceptions, are composed largely of persons who occupy essentially laymen's roles: people who have met terminal illness as patients, relatives of patients, or friends of patients, and not in professional roles. Advocates of suicide in terminal illness tend, generally, not to know much about the theory and clinical characteristics of suicide

behavior, and so are less able to see specific terminal-illness cases against the larger scientific background. Suicide advocates often tend to see each case as unique, and not as part of a larger demographic pattern. It is some familiarity with these larger patterns, and the characteristics of suicide of various sorts, that the research and clinical expertise developed within suicide-prevention groups might contribute to the suicide-advocacy cause. In particular, suicidologists, drawing on recent work in thanatology, might hope to contribute some knowledge of the stages of denial, anger, bargaining, depression, and "acceptance" in the approach to death, and the most likely moments in the course of a typical terminal illness at which suicide or suicide attempts may occur. For instance, it may be of considerable relevance to know whether suicide in terminal illness usually occurs, say, in anger or depression, or whether it more commonly occurs as a kind of demonstrable decathexis, the ultimate leavetaking from the world. Such facts may vary from one cultural group to another, or in different types of terminal disease. The actual facts of suicide in terminal illness are very little known; there is a vast amount of research work to do in describing general trends and demographic patterns of suicide in these difficult circumstances.

But each case of suicide <u>is</u> in a sense unique, and it is this fact which suicide-advocacy may hope to point out to the suicide-prevention groups. In suicide-prevention's zeal for declining suicide rates, this fact is perhaps all too easy to forget; all suicides are preventable, perhaps, but it is not so clear that each single one should be stopped.

What suicide-advocacy stands to contribute to the work of suicide prevention is a new sensitivity to the issue of when suicide-prevention is no longer humane, and the reminder that one consequence of effective suicide prevention can be to force people in intolerable circumstances to stay alive. As I have said, suicide prevention has been partly shielded from this problem by the widespread practice of not reporting suicide in the more sympathetic terminal-illness cases as "suicide" at all, but this shielding may border on self-deception. It is easy to think that one's work is always right if one can avoid noticing the cases in which it may be wrong. What suicide-advocacy can bring to suicide-prevention is a reminder not only that sympathic cases do occur, but that in certain central ways they are quite unlike other sorts of suicide cases -- despite the common trends and demographic patterns -- and should be treated in very different ways.

After all, suicide-advocacy, like suicide-prevention, is humanitarian at root: each has - or should have - the interests of individual human beings at heart. It is this fact of underlying humanitarian aim which provides the basis for accommodation between the two apparently inimical groups. But what is needed is something more than mere disinterested coexistence -- rather, genuine interaction and exchange, in which suicide-prevention supplies the background scientific view for a careful look at suicide in the as yet essentially unexamined area of terminal illness, and suicide-advocacy supplies the vision which insists that in doing so, the individual's interests always be kept at heart. Both suicide-prevention and suicide-advocacy are sometimes irresponsible, each in its own way: suicide-prevention's failings in this area might be labelled callousness,

those of suicide-advocacy naivété. Both sorts of irresponsibility can be avoided, I think, if there is genuine partnership between the two groups.

Finally, a pragmatic reason may suggest itself for suicide-preventers to attend to the claims of suicide-advocates: it may well be that more open attitudes on the question of whether suicide is sometimes permissible will increase the use of suicide-prevention's traditional services, particularly hotlines and crisis counseling centers, by those who are serious suicide risks. It is sometimes suggested that any attention to the claims of suicide advocacy, or any greater permissiveness in attitudes towards suicide, would weaken the efforts of suicide prevention and cause additional suicides among those who are not terminally ill. But if it is the case that some persons who are serious suicide risks do not seek help from hotlines and counseling centers because they do not want to be antecendently dissuaded or forcibly prevented from an act they are seriously considering, then it might well be expected that they will be more likely to use such services in a less rigidly preventive atmosphere. After all, these are the persons who may need suicide counseling most, and these are also the persons hotlines and crisis counseling services seldom see. In some cases, suicide prevention may very well not be humane. But in many cases, an openness to this possibility will make possible treatment for persons for whom suicide prevention <u>is</u> humane, and who otherwise would not present themselves. Thus, some attention to the claim of suicide-advocacy may serve not only the interests of terminal illness victims, but of serious suicide risks within the population as a whole.

EUTHANASIA AND SUICIDE ADVOCACY GROUPS

U.S.A.

CONCERN FOR DYING (1967)
250 West 57th Street
New York, N. Y. 10019

SOCIETY FOR THE RIGHT TO DIE (1938)
250 West 57th Street
New York, N. Y.

AMERICAN EUTHANASIA FOUNDATION (1972)
95 North Birch Road, Suite 301
Fort Lauderdale, Florida 33304

HEMLOCK (1980)
2803 Ocean Park Blvd., Suite 101
Santa Monica, California 09405

Britain — EXIT, THE SOCIETY FOR THE RIGHT TO DIE WITH DIGNITY (1935)
13, Prince of Wales Terrace
London W8 5PG, England

Australia — VOLUNTARY EUTHANASIA SOCIETY OF VICTORIA (1974)

AUSTRALIAN VOLUNTARY EUTHANASIA SOCIETY (1974)

WEST AUSTRALIAN VOLUNTARY EUTHANASIA SOCIETY

Norway — LANDSFORENINGEN MITT LIVSTESTAMENT RETTEN TIL EN VERDIG DOD

Sweden — AKTIONSGRUPPEN RETTEN TILL VAR DOD (RTVD) (1973)

Japan — JAPAN EUTHANASIA SOCIETY (1976)

Denmark — MIT LIVSTESTAMENTE RETTEN TIL EN VOERDIG DOD (1976)

New Zealand — VOLUNTARY EUTHANASIA SOCIETY (1978)

VOLUNTARY EUTHANASIA SOCIETY OF AUCKLAND (1978)

South Africa — SOUTH AFRICAN VOLUNTARY EUTHANASIA SOCIETY (1974)

Holland — NEDERLANDSE VERENIGING VOOR VRIJWILLIGE EUTHANASIE (1973)

INFORMATIECENTRUM VRIJWILLIGE EUTHANASIE (1975)

STICHTING VRIJWILLIGE EUTHANASIE (1973)

Germany — INITIATIVE FÜR HUMANES STERBEN NACH WUNSCH DER STERBENDEN (1976)

France — ASSOCIATION POUR LE DROIT DE MOURIR DANS LA DIGNITE (1980)

Colombia — SOLIDARIDAD HUMANITARY

Zimbabwe — (group forming)

Canada — COMMITTEE FOR DEATH WITH DIGNITY, TORONTO (group forming)